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Vol. XL No. 12

ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the
Albany Medical College

DECEMBER, 1919

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ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the Albany Medical College

EDITED BY
J. MONTGOMERY MOSHER, M. D.

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Publisher's Department

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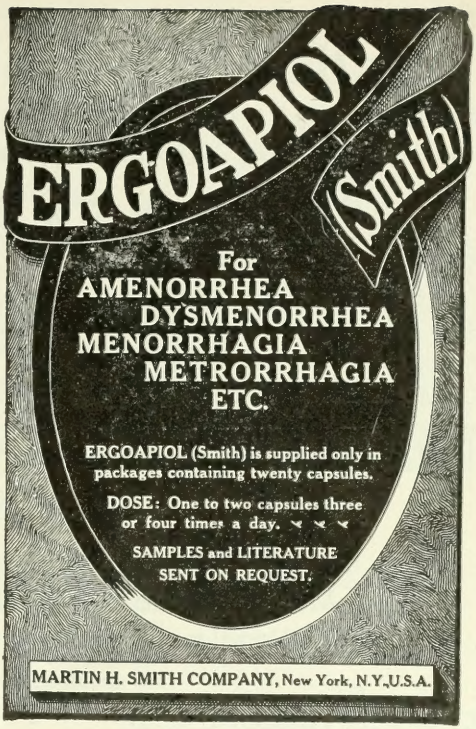

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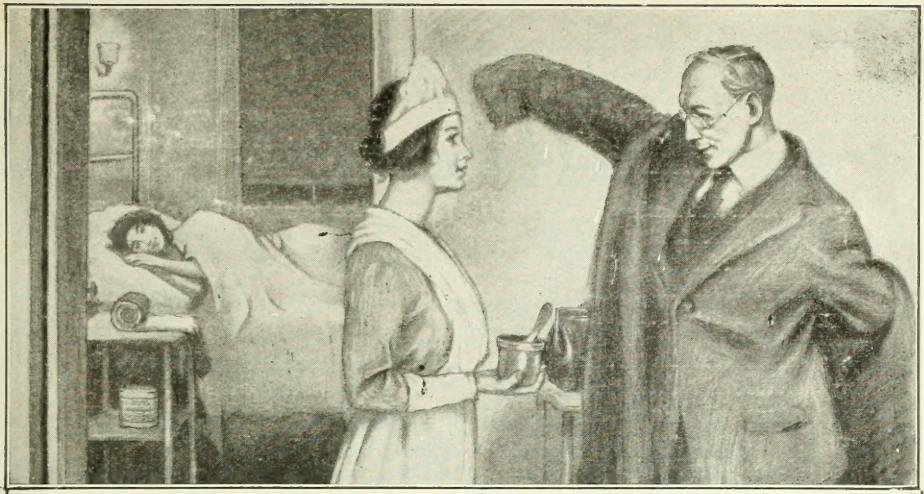

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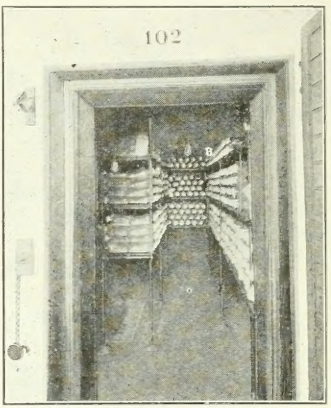

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Publisher's Department

PROPHYLAXIS AND TREATMENT OF INFLUENZA AND INFLUENZA PNEUMONIA.—Dr. E. C. Rosenow, of the Mayo Clinic, has probably done more to determine the prophylactic value of vaccines in influenza than any other individual in the country. He reported on the use of a prophylactic vaccine last winter. There were 100,000 cases under observation, with 300,000 controls. He declared that the incidence of influenza was about three times as common and the death-rate five times as high among the uninoculated as among the vaccinated persons.

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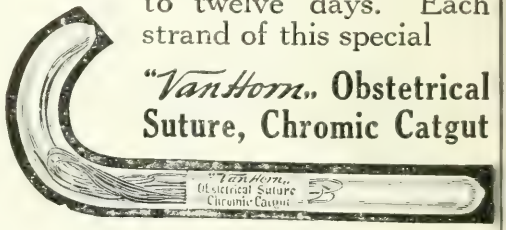

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VOL. XL DECEMBER, 1919 No. 12

ALBANY MEDICAL ANNALS

Original Communication

VALVULAR DISEASE OF THE HEART

Read before the Washington County Medical Society, October 7, 1919.

BY D. C. McKENZIE, M. D.,
Granville, N. Y.

Valvular disease of the heart may be caused by many conditions. The lesions may be congenital, they may be caused by many acute diseases, by focal infection or by any condition that produces a degeneration of the heart muscle. Arterio-sclerosis may also be a cause. Probably the greatest number of cases follow an attack of acute articular rheumatism.

There are four elements that enter into and cause the normal heart sounds: (1st) muscular contraction, (2nd) closure of the valves, (3rd) stretching of the chordæ tendinæ (4th) the contraction of the papillæ.

The heart sounds are known as the first and second sounds. The first or longer sound is heard at the contraction of the ventricles, the second or shorter sound is heard at the contraction of the auricles. Any condition that interferes with the proper action of the valves of the heart causes the so-called murmur. A murmur may be so slight as to be scarcely heard or may be so great as to completely displace the normal heart sound.

In listening to murmurs of the heart there are four important points to remember: (1st) time, (2nd) location, (3rd) transmission, (4th) quality.

Time. You must be able to tell whether the murmur is systolic, presystolic or diastolic in time. The best place to time a murmur is to put your finger on the carotid: a beat in the carotid corresponds with the first sound of the heart or the systole of the left ventricle. Presystolic or diastolic murmurs are always heard when the ventricles are relaxed.

Place. You must decide where the murmur is best heard, whether over the apex or base of the heart and whether in the aortic, pulmonic or mitral area. The aortic area is situated at

the second intercostal space to the right of the sternum. The pulmonic area is at the second intercostal space at the left of the sternum. The mitral area is at the apex of the heart.

In general all murmurs heard at the aortic area are aortic murmurs and all murmurs heard at the apex are mitral murmurs, so murmurs may be generally classed as follows:

A systolic murmur heard at the apex—mitral regurgitation;

A presystolic murmur heard at the apex—mitral stenosis;

A diastolic murmur heard at the aortic orifice—aortic regurgitation;

A systolic murmur heard at the aortic area—aortic stenosis.

All murmurs are either regurgitant or stenotic. The transmission of a murmur is very important. Mitral regurgitation is heard at the apex and is transmitted in the same intercostal space to the axillary line, at the nipple and may often be heard on the back at the angle of the scapula. Mitral stenosis is heard at the apex and is transmitted to the right, one-half inch beyond the border of the sternum.

Aortic regurgitation is heard in three places: over the aortic area, at the fourth intercostal space on the left close to the sternum and at the ensiform cartilage. Twenty-five per cent are heard over the aortic area, fifty per cent are heard at the ensiform cartilage, but one hundred per cent must be heard at the fourth left intercostal space. This murmur is transmitted to the left in the fourth intercostal space and often, in following this murmur along this space, as you approach the axillary line, the murmur loses its soft blowing character and you hear a rumbling harsh murmur very suggestive of mitral stenosis—in fact it is very difficult to distinguish between them. This murmur is known as the Austin Flint murmur.

Aortic stenosis is heard at the second left intercostal space and is transmitted to the carotid, the clavicle and at times may be heard down the whole length of the spine.

As to quality, murmurs are always soft or harsh. Regurgitant murmurs are always soft, stenotic murmurs are always harsh.

In disease of the heart we may learn a great deal from the inspection of the patient that will aid us in arriving at a correct diagnosis.

Dyspnœa caused by exertion that is relieved by rest in the re-

cumbent position is in the majority of cases due to mitral disease. There are several varieties of dyspnoea. In the terminal stage of heart disease where we have dilatation and loss of compensation we have constant dyspnœa and this is made worse by lying flat on the back; this is to be distinguished from the dyspnœa of emphysema in which the patient is more comfortable on his back.

The dyspnœa due to Stokes-Adam syndrome is characterized by the extremely slow breathing, sometimes there being only six or eight respirations to the minute. There is another kind of dyspnœa that has no reference to the heart and is known as the Cheyne-Stokes respiration. This was formerly thought to be the sure forerunner of death, but we know that this often occurs and still the patient recovers. However, if this occurs in meningitis, nephritis or diabetes we are very apt to have a fatal termination. We get a certain amount of dyspnœa in arterio-sclerosis. This is probably due to the sclerotic changes in the heart itself and it is for this reason that we get more dyspnœa in chronic interstitial nephritis than we do in chronic parenchymatous nephritis.

If, on examination of the patient, you find œdema of the feet and legs that disappears when in bed you may be sure that the trouble is mitral. This kind of œdema is called ascending œdema in contra-distinction from the œdema that occurs in the face, eyelids, etc., which is always due to kidney trouble and is known as descending œdema. There is one other kind of œdema that may be mentioned and is called idiopathic lateral œdema. One leg may be swollen from the toes to the hip without œdema in any other part of the body. This may be due to some pressure on the venous supply by a large fecal mass or some new growth.

If in a patient after exertion you find his lips become blue and his skin more or less cyanotic you may be sure you are dealing with trouble at the mitral valves, while on the other hand if the patient becomes pale and faint you may be sure you have trouble at the aortic orifice. If the patient is cyanotic all the time you probably have the terminal stage of heart disease.

An enlarged heart may be due to hypertrophy or dilatation, which you cannot tell by percussion, but on inspection in the dilated heart the heart is always in a state of tremor, hence the apex beat is seen covering a wide area and the heaving impulses

are widely distributed, while in hypertrophy we get one large heaving impulse at one point.

We may also see a pulsation at the ensiform cartilage and this is due to hypertrophy of the right heart. Hypertrophy of the right heart may be due to emphysema or may be secondary to trouble in the left heart.

To find the normal apex beat in the male, measure one inch to the right from the nipple, draw a perpendicular line through this line, then draw a transverse line along the fifth interspace, and where these lines cross will be the normal position for the apex. In the female, where the nipple cannot be used as a guide, draw a line at the left border of the sternum and a line at right angles to this in the fifth intercostal space, then measure on the horizontal line two inches from the border of the sternum, and this will be the normal position of the apex.

In children the normal apex is found in a different position and this is found by placing the child on his back and laying the left arm parallel with his body, now draw a line close to and parallel to the arm from the axilla and a second line at the left border of the sternum, now connect these two lines with a line drawn in the fifth interspace, and a point on this line equally distant from the other two lines will be the normal apex for a child.

We may have a displaced apex due to different conditions. If the apex is displaced but still remains in the fifth intercostal space it is due to mitral regurgitation. If the apex is displaced to the left and downward to the sixth, seventh or eighth interspace then it is due to aortic regurgitation, for, as you know, in this we get a great amount of hypertrophy of the heart. If you find the apex in the fourth intercostal space then you have mitral stenosis, for in this disease the left ventricle has less work to do and so becomes smaller. If the apex is not displaced to the right or left but downward to the sixth interspace this is probably due to chronic nephritis, as the hypertrophy caused by nephritis is in a longitudinal rather than in a transverse direction, as it is in primary heart conditions. So we see that from these facts alone it might be possible to make a diagnosis even if no murmur had been heard.

If you have a pericardial effusion that is slight you will have

no change in the apex beat, but if great in amount the apex beat will be entirely lost. To prove whether there is fluid in the pericardium put the patient in the Trendelenburg position, when the fluid will gravitate to the base of the heart and the apex beat will again appear. If the precordium of a child is bulging you probably have hypertrophy of the heart, but if this occurs in the adult you probably have an effusion in the pericardium.

Pulsation of the arteries of the neck is only seen in aortic regurgitation or goiter. If the jugular veins are turgescent and pulsating the trouble is in the right heart and we have to deal with tricuspid regurgitation.

We may learn some very interesting things from palpating the pulse. It is best to feel the pulse in both arms at the same time, for often the right radial pulse is anatomically smaller than the left, and, another reason, one of the radial pulses may be missing. If this is so then look for the brachial artery, and, if found, there is probably some anatomial defect; but if the brachial is missing you probably have to deal with an aneurism of the arch of the aorta.

In arterio-sclerosis you can often judge the amount of sclerosis by the radial artery, and if found here it is apt to be found throughout the whole arterial tree. The reverse, however, is not true, for in many people, especially fleshy people, we find a sclerosed condition of the smaller arteries which is not found in the radials. By palpation you may distinguish three stages to the sclerosed radial artery: (1st) when you can roll the artery like a pipe under your finger, (2nd) the first stage plus a tortuous artery, and (3rd) the first two stages plus the deposit of calcareous material in the walls of the artery; this condition we call atheroma. When arterio-sclerosis is due to an infection its course is rapid, six months to one year, but when not, the course is very slow, often extending over a period of twenty years or more.

In the diagnosis of heart disease, if a man has a normal heart the position of the arm does not change the rate or pressure of the pulse. In ninety per cent of the cases of mitral regurgitation the pulse will be less with the arm in the upright position. If the difference is only slight it shows that the heart muscle is in fairly good condition, if the difference is very much it shows that the

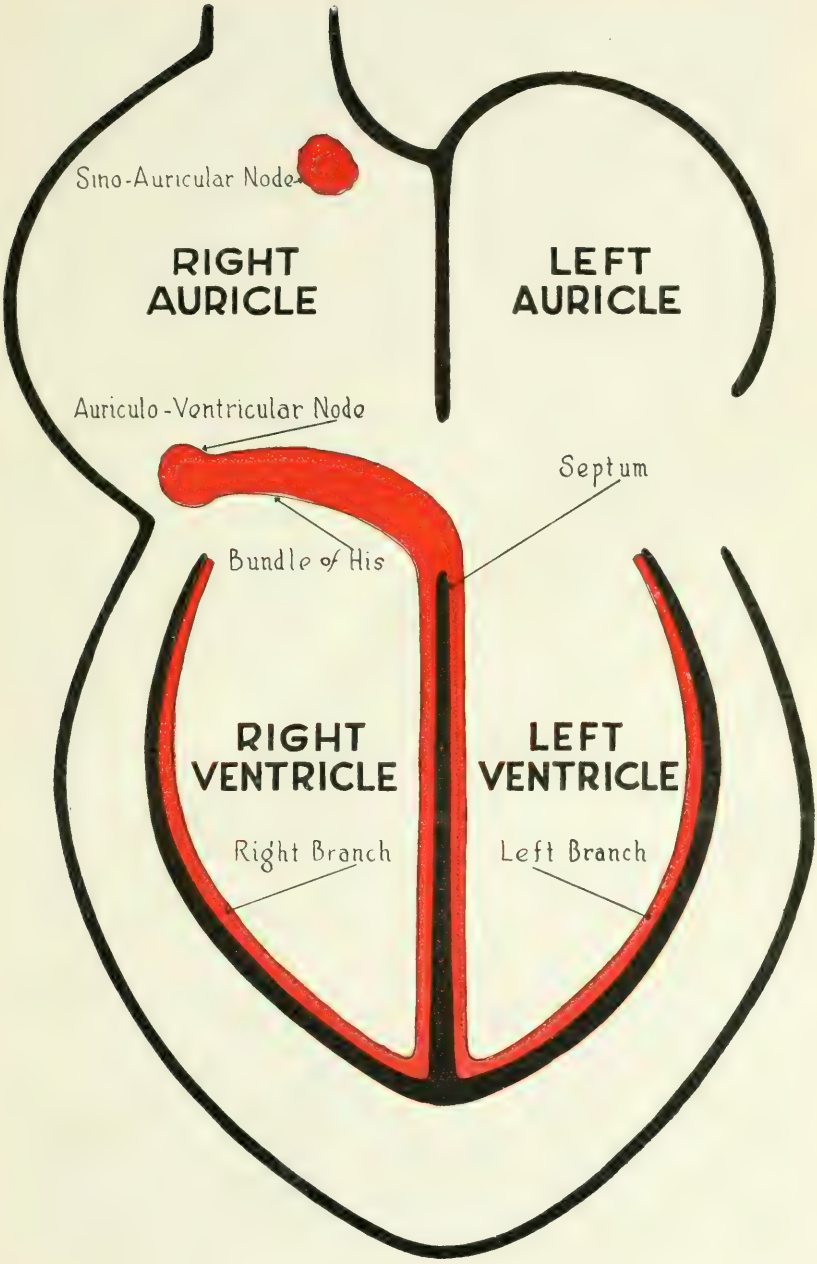
heart muscle is poor and the prognosis is not so good, but if the pulse is gone it shows that the muscle is decompensated and the prognosis is very bad. If the pulse stays good little or no treatment is needed.

In aortic regurgitation you get the Corrigan pulse. This is caused by the large heart contracting with great force, and the cavity of the left ventricle being large, a large amount of blood is forced into the artery, but as the valves are incompetent the blood rushes back at the end of contraction and we have what is known as the waterhammer pulse. This is the only disease in which we get this pulse. We also find the pulse in the uplifted arm in this disease shows this peculiar pistol-shot character more than when in the prone position.

In aortic stenosis the pulse is slow and does not change when the arm is in the upright position. We can learn a good deal from the rate of the pulse. A pulse of thirty-five in the absence of aortic stenosis spells heart bloc, if below twenty, complete heart bloc. You may have a slow pulse in typhoid fever and meningitis but later it becomes intermittent; you may also get a slow pulse in diabetes. You have a rapid heart in scarlet fever and if it becomes slow during the course of the disease look out for nephritis. In dilated heart and myocardial degeneration we get a rapid weak pulse. In uræmic coma we get a rapid pulse of high tension while in diabetes we get a slow pulse of low tension. A pulse of one hundred is never physiological.

In this connection I want to say a few words in regard to heart bloc. Although not a valvular disease it is so often accompanied by valvular disease and myocardial degeneration that it may not be amiss to spend a few moments in an explanation of this somewhat frequent heart condition. For this purpose I have made this rough drawing which may help to make clear what I have to say.

Before we can understand a derangement of the heart's action a detailed knowledge of the mechanism of the normal cardiac contraction is necessary. The succession of events constituting a normal cardiac cycle is initiated by a stimulus originating in a small mass of highly sensitized tissue at the junction of the superior vena cava and the right auricular appendix, and is called the sino-auricular node. Successive stimuli are generated


Sino-Auricular Node
RIGHT AURICLE
LEFT AURICLE
Auriculo-Ventricular Node
Septum
Bundle of His
RIGHT VENTRICLE
LEFT VENTRICLE
Right Branch
Left Branch

at this node with absolute regularity during periods of about eighth-tenths of a second, each thus determining the duration of a normal cycle. The sino-auricular node is normally the most excitable portion of the heart and determines both the rate and rhythm of the heart, or, rather the cardiac contractions, and is therefore called the "Pace Maker."

Under normal conditions, all cardiac activity is initiated by this node and directly or indirectly is the result of the exercise of this nodal function. In various cardiac derangements stimuli to contract may originate elsewhere, invariably, however, producing an abnormal mechanism. The further removed from this node the area producing such abnormal stimuli, the more slowly they are generated. The ventricles possess this function in a relatively slight degree and if exercised it produces a rate very much slower than that which comes from the sino-auricular node. In other words the venous end of the heart is very active while at the apex this function is only slightly developed.

The stimuli originated at the venous end of the heart to be effective must be propagated over the heart in an orderly and regular manner. The stimulus waves originating in the sino-auricular node spread from above downward and from right to left over the walls of the auricles, exciting them to contract. This excitation wave reaches the ventricles, not by direct extension over the heart walls, as in the case of the auricles, but by the way of a special conducting system, as is shown in the diagram. This excitation wave after passing over the walls of the auricles collects or passes to a point called the node of Tawara, or the auriculo-ventricular node, and it is at this point that the conducting system originates. This node is located low down in the wall of the right auricle posteriorly beneath the endocardium. The continuation of this node is called the bundle of His. This connecting band after a short course divides like a hair pin into two main branches, the right and left. The branches lie on either side of the septum separating the ventricles and run parallel with their respective cavities. These branches subdivide till they form a network throughout the whole ventricular walls.

We note then that the continuity is not broken, and, though called by different names, it is still composed of the same highly specialized tissue as the sino-auricular node. Hence it must be

understood that this special conducting system is the only pathway by which the functional activity originating in the sino-auricular node and conducted over the auricular walls may be farther conducted to the ventricles. This neuro-muscular band, originating in a node and continued through the branches to all parts of the ventricles, is the bridge that connects the auricles with the ventricles.

This conduction system receives its blood supply from a special branch of the right coronary artery. The sino-auricular node receives fibers from the branches of the right vagus and the auriculo-ventricular node receives fibers from the left vagus. A similar division of the right and left accelerators occurs.

Contractility. This is obviously the most necessary of the myocardial functions; however, the contractions of the heart are dependent upon the exercise of certain other functions of the myocardium. It is to be remembered that the stimulus wave and the contraction wave are the result of the exercise of separate and distinct functions although necessarily there is normally an intimate and immediate relation between, provided a fourth function (excitability or irritability) is present. Thus we have four myocardial functions closely associated that produce a normal heart beat, namely, stimulus production, conductivity, excitability, and contractility. Interference with any of these will affect in different ways and varying degrees the cardiac cycle.

We note that this cycle is made up of a series of events initiated by the sino-auricular node generating stimuli in regular order, the stimuli being conducted along a definite pathway to all parts of the auriculo-ventricular myocardium and resulting in a contraction of the heart from above downward in such a way as to make its muscular and valve actions most effective in propelling the blood onward into the vascular system. The contracting of the auricles before the ventricles completing the filling of the latter chambers increases the heart's efficiency.

Departure from the normal mechanism of cardiac contraction will result in interference with the work of the heart and the signs of disturbance of one or more of its functions. The time elapsing between the beginning of auricular contraction and ventricular activity constitutes a measure of the activity of the conducting system and this may be absolutely determined by the

electrocardiograph. The normal conduction time does not exceed two-tenths of a second.

Heart bloc then is the mechanical derangement of the heart's contractions caused by impaired function of the conducting system, resulting in circulatory impairment of various degrees. The loss of the function on the part of the bundle and its branches may be of any grade. With slight involvment there may be evident only slight delay in conduction time beyond the normal, more extensive damage may result in a greater or less number of auricular beats failing to excite a corresponding number of ventricular beats and this condition is known as partial heart bloc.

If the damage is so extensive as to produce a complete loss of function of the conducting system we have then a complete dissociation between the auricles and the ventricles and this condition is known as complete heart bloc, and here the auricles and ventricles each beat with their own time and rhythm. In complete heart bloc the ventricles beat with their own inherent stimulation and usually at the rate of about thirty to the minute and this rate is not affected by influences that usually affect and quicken the heart.

Complete heart bloc, if it continue for any length of time, has a very unfavorable prognosis. In partial heart bloc the usual rate is two to one; that is, the ventricles beat just half as often as the auricles. The milder forms of heart bloc can only be told by means of the electrocardiograph. Partial and complete heart bloc may alternate, the change from one rhythm to another occurring frequently.

It is unnecessary to enumerate the symptoms of heart bloc and I will only say that ventricular inactivity for three or four seconds will cause a feeling of dizziness or goneness; syncope will result from a silence of eight or nine seconds. After a silence of fifteen or more seconds, owing to the action of carbon dioxide on the motor centres of the brain, tonic and then clonic convulsions will appear in the muscles of one side of the face and arm. These usually come on without warning and the patient may suddenly fall. They may be distinguished from epilepsy, as there is no warning cry, no nausea or vomiting, biting of the tongue or loss of control of the sphincters.

Treatment. In the treatment of valvular disease of the heart

we must, as in many other diseases, treat each case on its own merits. Because when we listen to a patient's heart and hear a murmur it is no sign that patient needs a course of digitalis. We must go into the history of the case and find out if possible whether the heart condition is primary or secondary.

In a short paper of this kind it is impossible to say much in regard to treatment except in a general way. I wish however to give you ten reasons for treating the heart. If you have a patient with a heart lesion who shows one or more of these conditions it is an indication that you should look after the heart; if none of them are present it is pretty good evidence you should not treat the heart but that you should look to some other organ for the existing trouble. The indications are: (1st) Dyspnœa, (2nd) Cyanosis, (3rd) Oedema, (4th) Hæmoptysis, (5th) Large Liver, (6th) Anginal Pain, (7th) Diminished pulse taken while the arm is in the upright position, (8th) Auricular Fibrillation, (9th) Cough, (10th) Insomnia and Hallucinations.

In general, digitalis should be used in diseases of the left heart and convallaria in disease of the right heart. Another general rule in giving digitalis: it is best, if giving it for any length of time, to give it only five days out of each week. A good plan to follow is the first day to give one grain of calomel in tenth-grain doses, the next five days to give your digitalis and on the last day of the week to repeat your calomel in the same way. When giving digitalis it is advisable at least to give occasional doses of calomel. If using the tincture a good way to prescribe it is in a half ounce of Fairchild's essence of pepsin.

Mitral regurgitation is the most frequent of all valvular troubles, estimated to be about eighty-five per cent. In this condition we recognize three stages: (1st) where the murmur is heard at the apex and not transmitted, (2nd) where the murmur is heard at the apex and transmitted to the nipple, in the fifth interspace to the axilla, and is heard at the back at the angle of the scapula, (3rd) the second stage plus symptoms of failure of compensation, such as dyspnœa œdema, etc. The first two stages, unless an acute condition, call for no treatment; if acute, rest in bed, small doses of digitalis with calomel, and, as the greatest number of cases are due to rheumatism, give twenty grains of sodium salicylate with twenty grains of sodium bicarbonate three times a day for at least a month or two.

In the third stage, if symptoms of decompensation are very marked and the patient is in a desperate condition, we may use very large doses of digitalis. One drachm of the tincture may be given, and if no improvement follows, it may be repeated in twelve hours and as many as three or four such doses may be given at twelve-hour intervals; after that reduce the dose to thirty or forty drops, later to twenty, and continue at that dose.

Mitral stenosis presents two stages which may be termed (1st) bad, (2nd) worse. This trouble needs treatment in both stages. In the first stage do not use digitalis but use tincture of strophanthus, five or ten minims, three times a day. It is twice as strong as digitalis and unless of good quality will produce diarrhœa. Later give the strophanthus twice daily and later only once at night. There is only one indication where digitalis should ever be used in the first stage and that is when it is accompanied by auricular fibrillation; then you give twenty minims of the tincture three times a day. In the second stage use tincture of digitalis in forty minim doses, *t. i. d.*, and gradually reduce to twenty minims, *t. i. d.*

In aortic regurgitation, the first stage, in which the murmur alone is present, is very short, lasting about ten weeks, and during this stage no treatment is needed other than rest, but in the second stage, where you have dizziness, insomnia, dyspnœa, etc., there has been a good deal of discussion as to whether digitalis is indicated or not, as it prolongs the diastole and theoretically is not indicated; but I believe now that most men think that digitalis is the drug to use. You must begin with the minimum dose and increase one drop each day till you reach twenty drops, then reduce the dose in the same way, never giving more than twenty drops to the dose. If you have sclerosed arteries with this condition it may be well to combine it with nitroglycerine.

Oedema may result from the failure of compensation, both in the right and left heart. With this present in only a mild degree put the patient to bed and give tincture of digitalis, twenty minims, *t. i. d.*, preceded by calomel in the method spoken of earlier in this paper. When the œdema is great, causing the so-called dropsy, we may use several different treatments: (first) the calomel treatment, which consists in giving three grains of calomel three times a day for three days. You will not get more

than four to six bowel movements but will get very marked effect on the kidneys. In using this treatment you must use a mouth-wash every hour of potassium permanganate, one to one thousand and give five grains of sodium bicarbonate with each dose of calomel to prevent ptyalism. The calomel treatment does not work so well after the dropsy has recurred three or four times.

In children the same treatment may be used, giving the calomel in one and one-half grain doses. There is only one contraindication for this treatment and that is a chronic nephritis of the parenchymatous type where there are much albumen and many casts. Any heart patient of long standing will show albumen in the urine and this should not be mistaken for nephritis, hence use calomel if only traces of albumen in the urine.

The second method, indicated in extreme cases: take six grains of calomel, three drachms of compound jalap powder and three-tenths of a grain of elaterium, divide into three powders and give one powder every two hours till all are taken. This acts more on the bowels than on the kidneys.

The third method. This is used in cardiac or renal dropsy or a combination of both. Give diuretin in twenty grain doses every two hours till twelve doses are given, then stop. May use this in children in five-grain doses.

The fourth method consists in giving the Neahmiah or Tyson pill and this contains calomel, one-quarter grain, extract of squills, one grain, powdered digitalis leaves, one grain. Give one every three hours till twelve are taken. This pill is said to be the same as the much advertised anasarcin tablet.

The fifth method is by the us of apocynin, which is given in the so-called cymerin tablet, which is silver-coated. The dose is one or two tablets every three hours. This is a cardiac stimulant and you do not need to use digitalis while giving this.

Without going farther into the treatment of these heart conditions we might sum up by saying that digitalis is indicated in all conditions of cardiac insufficiency where the heart is unable to carry on the circulation, remembering that under no conditions can digitalis increase the absolute power of the heart—it merely enables it to use to better advantage the power it has left.

Before closing this paper I wish to say a few words in regard to the pulmonic area of which I neglected to speak earlier. The

pulmonic area, sometimes called the "Area of romance," is extremely interesting. In mitral stenosis it is of value in two ways: first, there is a marked accentuation of the second pulmonic sound; second, in advanced cases, there is a strong heaving impulse visible in this area.

The accentuation of the second pulmonic sound is of material help in the diagnosis of mitral insufficiency. It is never absent except in cases of extreme dilatation of the right heart. The accentuation of the second pulmonic sound has considerable differential value. Suppose a systolic murmur is heard over the apex and is not transmitted anywhere. The question arises, is the murmur an indication of mitral regurgitation or is it a functional murmur? The presence of an accentuated second pulmonic sound would stamp the murmur as organic while its absence would argue in favor of a functional murmur.

The accentuation of the second pulmonic sound is one of the very early signs of incipient pulmonary tuberculosis and is rarely absent. It is, however, only present in early cases. It is not known to exist in advanced cases. Hence accentuation of the second pulmonic sound suggests two widely separated conditions; mitral disease and early tuberculosis of the lungs. As mitral disease can be easily ruled out, the pulmonic accentuation calls for the examination of the lungs, especially the apices.

The pulmonic area plays an important part in the prognosis and treatment of pneumonia. It is known that in pneumonia the heart is more important than the lungs and that the right heart is more important than the left. Most deaths from this disease are caused by failure of the right heart. The strength of the right heart is measured by the accentuation of the second pulmonic sound.

As long as that sound is louder than the second aortic and as long as that sound is thumpy the patient is doing well; just as soon however as the pulmonic second begins to weaken there is ground for alarm; when that sound becomes inaudible the prognosis is very grave. In the treatment, so long as the second pulmonic is accentuated, and as long as the valves close with a thud, the heart needs no stimulation, but the slightest impairment of the accentuation is the signal for the administration of stimulants. Marked impairment is the summons for the employment of continuous and powerful heart stimulants.

Public Health

DEPARTMENT OF PUBLIC SAFETY, BUREAU OF HEALTH, ALBANY, N. Y.
BUREAU OF VITAL STATISTICS.

Edited by Arthur Sautter, M. D.

COMPILED BY WILLIAM F. FULLGRAFF, REGISTRAR.

DEATHS FOR THE MONTH OF OCTOBER, 1919.

Consumption	9	Bright's Disease	9
Typhoid Fever	1	Apoplexy	8
Scarlet Fever	0	Cancer	12
Whooping Cough	0	Accidents and Violence	14
Measles	0	Deaths under 1 year	11
Diarrheal Diseases	0	Deaths over 70 years	26
Pneumonia	4	Death rate	13.71
Broncho Pneumonia	6	Death rate less non-residents	10.54

Deaths in Institutions.

	Non. Res.	Res.		Non. Res.	Res.
Albany Hospital	15	10	Public Places	1	3
Albany Hospital Camp	1	1	St. Margaret's House	1	1
Albany County Hospital	1	1	St Peter's Hospital	3	6
Child's Hospital	2	..			
Homeopathic Hospital	4	6		29	34
Hospital for Incurables	1	1	Births		197
Home for the Aged	0	2	Still Births		10
Maternity Hospital	0	3			

DIVISION OF COMMUNICABLE DISEASES.

Typhoid Fever	2	Tuberculosis	16
Scarlet Fever	17	Mumps	12
Diphtheria and Croup	10	Pneumonia	14
Chickenpox	11	Influenza	16
Smallpox	0	Septic Sore Throat	18
Measles	6		
German Measles	0	Total	127
Whooping-cough	5		

Number of days quarantine for scarlet fever:
Longest..... 31 Shortest..... 30 Average..... 30⅓
Number of days quarantine for diphtheria:
Longest..... 17 Shortest..... 11 Average..... 15
Fumigations:
Rooms..... 116 Buildings..... 17
Milk bottles disinfected..... 82

Communicable Diseases in Relation to Schools.

	D.	S.F.	M.
Public School No. 4	..	4	..
Public School No. 5	..	1	..
Public School No. 7	1	..	..
Public School No. 10	..	1	..
Public School No. 18	1	..	..
Public School No. 22	..	1	..
St. Joseph's Academy	..	5	..
St. Ann's School	..	1	..

MISCELLANEOUS.

Cards posted for communicable disease	20	Inspections and reinspections	46
Cards removed	12	Vaccinations	47
Notices served on schools	95	Vaccination dressings	130
Notices served on stores and factories	8	Children examined for employment certificates	35
Postal card returns sent to doctors	20	Number of employment certificates issued	35
Postal card returns received from doctors	12	Taking specimens of blood for Wassermanns	8
		Taking smears for Gonococci	6

Tuberculosis.

Living cases on record October 1, 1919		898
Cases reported:		
By card	16	
Dead cases by certificate	0	16
		914
Dead cases previously reported	9	
Dead cases not previously reported	0	
Removed	4	
Died out of town	0	
Recovered	0	
Unaccounted for	0	13
Living cases on record November 1, 1919		901
Total tuberculosis death certificates		9
Non-resident deaths:		
Albany Hospital Camp	2	
C. F. L. Pavilion	0	
County Hospital	0	

St. Margaret's House	0	
City at large	0	2
Resident deaths		7
Visits to cases of tuberculosis		12
Miscellaneous visits		0

LABORATORY REPORT.

Diphtheria.

Initial Positive	36	Unsatisfactory	5
Initial Negative	261		
Release Positive	12	Total	323
Release Negative	9		

Sputum for Tuberculosis.

Positive	49	Unsatisfactory	1
Negative	116		
		Total	166

Widals.

Positive	0	Unsatisfactory	1
Negative	15		
		Total	16

Meningococcus.

Positive	0	Negative	0
		Total	0

Wassermann tests	328	Gonorrhoea examinations	65
Milk analyses	205	Miscellaneous examinations	1
Water analyses	0		
Pathological examinations	0	Total examinations	1,104

HEALTH PHYSICIAN'S REPORT.

Cases assigned	29	Calls made	53

DIVISION OF SANITATION.

Inspections		32	Reinspections		44
Plumbing	10		Plumbing	8	
Sanitary	22		Sanitary	36	

Hearings.

Hearings	3	Refuse	1
Cases heard	4	Filthy premises	1
Chicken	1	Drain	1

Disposition of Cases.

Reinspections	4

Division of Plumbing, Drainage and Ventilation.

Inspections		145	Smoke	0	
Old Houses	87		Blue or red	0	
New Houses	58		Peppermint	5	
Permits issued		63	Water test	11	
Plumbing	52		Houses examined		19
Building	11		Re-examined		44
Plans submitted		17	Valid	12	
Old buildings	10		Without cause	7	
New buildings	7		Violations		0
Houses tested		16			

Report of Removal of Dead Animals.

Horses removed	7	Cats removed	67
Dogs removed	26		
		Total	100

Division of Markets and Milk.

Public market inspections	19	Milk cans inspected	453
Market inspections	106	Milk cans condemned	0
Fish market inspections	9	Lactometer readings	78
Fish peddler inspections	0	Temperature readings	78
Slaughter house inspections	3	Fat tests	0
Rendering establishment inspections	4	Sediment tests	142
		Chemical tests	0
Pork packing house inspections	0	Cows examined	1,535
		Cows quarantined	4
Hide house inspections	0	Cows removed	16
Milk depots inspected	15	Complaints investigated	5
Stores inspected	40	Milk houses inspected	143
Dairies inspected	143		

Medical News

The Albany Guild for Public Health Nursing.—Statistics for October, 1919.—Number of new cases, 394; classified as follows: General nursing cases, 222; (a) charity, 94; (b) moderate income cases, 50; (c) metropolitan cases, 78; prenatal cases, no charge, 34; dispensary social service, 35; tuberculosis, 49; venereal disease, 13; hospital social service, 75; cases carried from last month, 433; total number of cases carried during month, 827. New cases classified as to disease: Medical, 48; surgical, 42; obstetrical, 0; still births, 1; babies, 53; miscarriage, 1; abortions, 2; (a) prenatal, 34; (b) confinement, 46; (c) maternity, 9; tuberculosis, 49; hospital social service, 75; venereal, 13; dispensary social service, 35; no diagnosis, 2.

Visits for Nurses (all departments).—Number of visits with treatment, 1,517; number of social service visits, 474; number of prenatal visits, 108; number of tuberculosis visits, 219; number of other visits, 272; number of visits for supervision, 48; number of venereal disease visits, 6; number of hospital social service visits, 217; total number of visits, 2,724.

General Nursing Department.—Cases reported by: physicians, 98; metropolitan agents, 35; dispensary, 12; home social service department, 34; patients or family, 43; other sources, 11; Albany Hospital social service department, 41; nurses, 23. Disposition of cases: Removed to hospital, 9; discharged cured, 61; discharged unimproved, 14; discharged to dispensary, 2; died, 7; discharged improved, 58; discharged to other care, 6; number of patients still under care, 625; (nursing, 121; venereal diseases, 31; social service, 81; dispensary social service, 0; tuberculosis, 391; total, 625); number of patients still under supervision: Venereal diseases, 53; social service, 63; tuberculosis, 235; number of cases carried into next month, 976.

Dispensary Report.—Number of clinics held, 89; number of new patients, 124; number of old patients, 573; total number of patients treated, 697. Classification of clinics held: Prenatal, 3; eye and ear, 18; venereal, 8; tuberculosis, see lung; dental, 0; surgical, 11; medical, 8; lung, 8; stomach, 0; nose and throat, 9; skin and genito-urinary, 4; gynecological, 8; neurological, 3; pediatrics, 6; total, 86.

Special Tuberculosis Department.—Number of patients under supervision not tubercular 0; number of tubercular patients under supervision, 0; disposition of cases: Number of patients sent to hospital, 3; number of patients returned from hospital, 1; number of patients died, 6; number of patients discharged, 0; number of patients getting relief, 6.

Hospital Social Service Department.—Number of new cases investigated, 75; number of new cases carried from last month, 28; total number of cases under care, 81 in hospital; number of calls to homes, 140; number of calls to hospital wards, 39; number of calls to dispensary, 13; number of calls in co-operation, 25; total number of calls, 217. Disposi-

tion of cases: Referred to Associated Charities, 2; referred to general nursing service, 1; referred to dispensary, 10; referred to private physicians, 1; discharged dead, 3; discharged to tuberculosis department, 0; discharged O. K. to go home, 34; discharged to hospital, 0; discharged to baby welfare, 0; discharged to Home for Aged, 0; discharged to reformatory, 0; discharged to Home for Feeble-Minded, 0; discharged lost, 1; discharged, moved out of town, 0.

Venereal Disease Department.—Number of cases carried from last month, 21; new cases, 13; total number of cases under care, 34. Disposition of cases: Discharged to hospital, 1; left town to attend clinic there, 1; left with permission, 1; total, 3; still under care, 31; total number of cases still under supervision, 53.

New York and New England Association of Railway Surgeons.—The twenty-ninth annual session of this association was held at the Hotel McAlpin, New York City, on October 20th, under the presidency of Dr. J. S. Hill, of Bellows Falls, Vt.

The attendance was far above the average and Dr. George Chaffee, the correspondence secretary, reports this meeting to have been one of the very best in the history of the association.

Officers elected for the ensuing year are as follows: President, Dr. Wm. B. Coley, New York City; first vice-president, Dr. J. F. Black, White Plains, N. Y.; second vice-president, Dr. Donald Guthrie, Sayre, Pa.; treasurer, Dr. James M. Hamilton, Rutland, Vt.; corresponding secretary, Dr. George Chaffee, 100 Hawley street, Binghamton, N. Y.; recording secretary, Dr. J. H. Reid, Troy, N. Y.

An Appeal for Human Emeryological Material, by William W. Graves, St. Louis.—"In 1906 I observed certain malformations of the human shoulder-blade, and in contributions to current literature I have given them the collective name—'the scaphoid type of scapula,' and pointed out some of its hereditary, clinical and anatomical significance.

"Probably the most important observation connected with this type of scapula in man is its age incidence, that is to say, it occurs with great frequency among the young and with relative infrequency among the old. There appear to be two possible explanations of this fact:

"Either

"A——one form of shoulder blade changes into the other during development and growth,

"or

"B—many of the possessors of the scaphoid type of scapula are the poorly adaptable, the peculiarly vulnerable, the unduly disease susceptible—the inherently weakened of the race

"I have attempted to answer these questions by seeking evidence in various directions and one of the most important of these has been a

study of intrauterine development of shoulder-blades. My investigations in this direction have been limited by the material at my disposal, which has been inadequate for a definite solution of this phase of the problem. I am, therefore, appealing to physicians for fetuses in any and all stages of human development.

"It is desired that the material, as soon as possible after delivery, be immersed in ten per cent formalin in a sealed container, and be forwarded to my address; charges collect. Due acknowledgment will be made to those forwarding material."

727 Metropolitan Building.

Personals.—Dr. James C. Hassall (A. M. C. '10), who has been a member of the medical staff of St. Elizabeths Hospital, Washington, D. C., for several years, has associated himself with the management of Fair Oak Villa, Cuyahoga Falls, O.

—Dr. Clarence Barth (A. M. C. '18), is assistant physician at the Hudson River State Hospital, Poughkeepsie, N. Y.

—Dr. H. Judson Lipes (A. M. C. '97), who served as surgeon with the Sixteenth Field Artillery, with the rank of major, has been cited for bravery and gallantry in action, as follows:

"As regimental surgeon he voluntarily accompanied Battery 'A' to its forward position, where he was continuously under fire from enemy artillery and machine guns. Here he constantly rendered first aid to the wounded and insured successful treatment and evacuation to the rear. Throughout the entire action, Major Lipes displayed a remarkable example of fearlessness and absolute indifference to personal safety."

—Dr. John J. Randall (A. M. C., '16) announces his purpose to resume practice on November 1, at Scotia, N. Y. After graduation Dr. Randall served as interne in New York hospitals, and in May, 1918, received a Commission as First Lieutenant in the Medical Corps of the Army and was assigned to General Hospital No. 16, at New Haven, Conn. He was transferred to Syracuse, and again to Mitchell Field, Mineola, Long Island, and has recently been discharged from service. In June, 1918, Dr. Randall married Miss Agnes Gruelick of Schenectady, formerly a nurse in the Albany Hospital.

—Dr. Henry Viets, who served in charge of the neurological and mental work of the United States Army Base Hospital No. 33, in Portsmouth, England, as captain, has recently begun the practice of neurological surgery with his office at 112 Marlborough St., Boston, Mass. Dr. Viets has received an appointment to the staff of the Massachusetts General Hospital, with special reference to combine service in neurology and surgery.

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NEW YORK STATE MEDICAL LIBRARY.

Edited by Frances K. Ray

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VOLUME XL

Ἀσφαλὲς καὶ ἔμπεδον ἔστω τὸ σὸν ἔδος. Ἐκ σκότου μὲν ἔξαγε φάος, ἐκ δὲ πάθους ἀναψυχήν

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Influenza and Pneumonia

PROPHYLAXIS: Dr. E. C. Rosenow, of the Mayo Clinic, read a paper before the American Medical Association at the last annual meeting in which he reported on the use of a prophylactic vaccine in the influenza epidemic of 1918-1919. There was a total of 100,000 cases, with 300,000 controls. He asserted that the incidence of the disease was three times as great in the unvaccinated persons as in the vaccinated, and the mortality five times as great.

Parke, Davis & Company's Influenza-Pneumonia Vaccine is prepared in accordance with the original formula and method of Dr. Rosenow. It is administered in three injections, at intervals of six or seven days.

Influenza-Pneumonia Vaccine
(Prophylactic)

Bio. 632. Three bulbs in a package.
Bio. 633. Three syringes in a package.
Bio. 634. Rubber-stoppered vials containing five mils.
Bio. 635. Rubber-stoppered vials containing twenty mils.

TREATMENT: Physicians who used Pneumonia Phylacogen last winter as a routine measure in the treatment of influenza gave an initial injection of 16 minims. The second day the dose was increased to 32 minims, the third day to 48 minims, and so on until convalescence was established.

When pneumonia had already developed, 16 minims of Pneumonia Phylacogen was administered immediately. Twelve hours later 32 minims was injected, and the dose was gradually increased every twelve hours until the critical period had been passed.

Pneumonia Phylacogen

Bio. 605. Bulbs of ten mils, one in a package.
Bio. 607. Bulbs of one mil, five in a package.

Send for our booklet, "Prophylaxis and Treatment of Influenzal Pneumonia."

Parke, Davis & Company

DETROIT

Chronic Invalidism is a very frequent sequel of Influenza.

Fellows' Syrup of the Hypophosphites

COMPOUND SYRUP

supplies the indispensable mineral salts required by the system together with the two potent dynamic agents, strychnine and quinine. It accelerates convalescence and restores strength and vigor

"The Standard Tonic for Over Half a Century"

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The academic year begins Sept. 22, 1919. All inquiries and other communications should be addressed to Thomas Ordway, M.D., Dean, Albany Medical College, Albany, N.Y.